



Volunteer Resources

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VOLUNTEER APPLICATION FORM

Date ____/____/____ (year/month/day)		All sections of this Application Form must be completed in full. Please attach a resume. Please Print Clearly.	
At which NHS Hospital do you want to share your time: (check any/all that apply)			
<input type="checkbox"/> Greater Niagara Hospital in Niagara Falls	<input type="checkbox"/> St. Catharines General Hospital	<input type="checkbox"/> Welland Hospital	
<input type="checkbox"/> Ontario Street in St. Catharines	<input type="checkbox"/> Port Colborne General Hospital	<input type="checkbox"/> Niagara-on-the-Lake Hospital	
<input type="checkbox"/> Douglas Memorial Hospital in Fort Erie	<input type="checkbox"/> NHS Wide		
PERSONAL DATA			
First Name		Last Name	
Address			
City	Province	Postal Code	
Home phone number ()		Alternate phone number ()	
E-mail address:			
Are you 14 years of age or over? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever been convicted of a criminal offence for which a pardon has not been granted or for which a pardon has been granted and subsequently revoked? <input type="checkbox"/> No <input type="checkbox"/> Yes- please list the offence(s), date(s), convictions(s)			
Have you pleaded guilty to, or been found guilty of, any criminal offence outside of Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No			
VOLUNTEER AREAS OF INTEREST			
1.	2.	3.	
PAST AND PRESENT VOLUNTEER EXPERIENCE			
Organization	Role	Start and End Dates	
Organization	Role	Start and End Dates	
DRIVER/VEHICLE INFORMATION			
Make of Vehicle	Model of Vehicle	License Plate Number	
1.			
2.			

(See Back of Form)

SKILLS

List your skills, qualifications or experience which relate to volunteering at the hospital.

GENERAL

Have you ever been a volunteer for the Niagara Health System or any of its hospitals? Yes No

From	To	Department	Site
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Have you ever been employed by the Niagara Health System or any of its hospitals? Yes No

From	To	Department	Site
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REFERENCES - do not list relatives

1	First Name:		Last Name:	
	Street Address:			
	City:		Postal Code:	
	Phone:			
	Email:			

2	Name:		Last Name:	
	Street Address:			
	City:		Postal Code:	
	Phone:			
	Email:			

AUTHORIZATION TO RELEASE REFERENCE INFORMATION

I understand and agree that the Niagara Health System will request information from the above named references in connection with my application for a volunteer position. I authorize the above named references to release all such information as requested. I also agree that no liability or damage shall accrue to the above named references as a consequence of their releasing such information.

Signature	Date (year/month/day)
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DECLARATION

1. I understand that any offer of a volunteer position would be conditional upon the following:
 - a. Following NHS "Communicable Disease Surveillance Program", everyone carrying out activities in patient care areas must have a 2-step tb test. Documented proof of immunity to chicken pox, measles, and rubella is also required;
 - b. my photograph being taken for identification purposes;
2. I understand that if accepted for a volunteer position, I agree to comply with the conditions of the volunteer position and the policies of the hospital.
3. I understand that if any statements made by me on this or any other document are untrue or misleading, this application may be rejected or will constitute sufficient grounds for termination of service.
4. I will not disclose or use, during or subsequent to my volunteer service with the Niagara Health System, any information (written, verbal, electronic, or other form) relating to patients, employees, volunteers or Hospital business.

Signature	Date (year/month/day)
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